ADVANCE DIRECTIVES FOR HEALTH CARE RULES

I Purpose

These rules are adopted to effectuate the intent of Chapter 231 of Title 18, Vermont Statutes Annotated (VSA), Advance Directives for Health Care and Disposition of Remains.

The State of Vermont recognizes the fundamental right of an adult to determine the extent of health care the individual will receive, including treatment provided during periods of incapacity and at the end of life. 18 VSA Chapter 231 enables adults to retain control over their own health care through the use of advance directives, including appointment of an agent and directions regarding health care and disposition of remains. During periods of incapacity, the decisions by the agent shall be based on the express instructions, wishes, or beliefs of the individual, to the extent those can be determined.

A durable power of attorney for health care, terminal care document, or advance directive executed prior to the enactment of 18 VSA Chapter 231 (September 1, 2005) shall be a valid advance directive if the document complies with the statutory requirements in effect at the time the document was executed or with the provisions of 18 VSA Chapter 231.

II Definitions

The definitions of terms contained in these rules are the same as those contained in 18 VSA Chapter 231 at 18 VSA § 9701. If any of such legislative definitions are amended, the amended definitions shall be the definitions of the terms contained in these rules.

III Advance Directive Forms and Related Issues

Form/Issue	Attachment
Advance directive, optional form with explanation	A
Clinician orders for life sustaining treatment	B
Do Not Resuscitate (DNR) order	C
DNR identification	D
Emergency medical standards	E
Experimental treatments	F

IV Advance Directives Registry

1. The Registry

The Advance Directives Registry is a secure, web-based database created by the Department of Health to which individuals may submit an advance directive or information regarding the location of an advance directive.

2. Access to Registry

The Advance Directives Registry is accessible to principals and agents and, as needed, to individuals appointed to arrange for the disposition of remains, organ procurement organizations, tissue and eye banks, health care providers, health care facilities, residential care facilities, funeral directors, crematory operators, cemetery officials, and the employees thereof.

3. Prohibitions to Access

In no event shall information in the Advance Directives Registry be accessed or used for any purpose unrelated to decision-making for health care or disposition of remains, except that the information may be used for statistical or analytical purposes as long as the participating individual's identifying information remains confidential.

4. Process

To submit, revoke, amend, or replace information in the Advance Directives Registry, mail the original advance directive or related document to:

Director of Health Surveillance
Advance Directives Registry
Department of Health
PO Box 70
Burlington, VT 05402-0070

Information regarding accessing information in the Advance Directives Registry may be obtained on the Department of Health's website:

http://www.healthyvermonters.info

Information may also be obtained by contacting the Department of Health in person, by mail, or by telephone at (802) 863-7200 or 1-800-464-4343.

5. Amendment, Suspension, Revocation

Notification of amendment, suspension, or revocation under 18 VSA § 9704(c) and revocations of appointment under 18 VSA § 9704(d) will be incorporated into the Advance Directives Registry.

ATTACHMENT A

ADVANCE DIRECTIVE FOR HEALTH CARE
Explanation and Instructions

An **Advance Directive** is a document you prepare to choose someone as your health care agent or to guide others to make health decisions for you. An advance directive can include instructions about your health care as well as what should happen with your body after you die. Having an Advance Directive helps when you no longer can or no longer wish to make your own decisions. As you begin your Advance Directive, here are some important things to know:

- You have the right to consent to or refuse any medical treatment.
- You have the right to appoint an ***agent*** to make decisions for you.
- You may use this Advance Directive to share your wishes ***in advance.***
- You may fill out all Parts of this Advance Directive form or just portions of it. For example, you can just appoint an agent in Part 1 and then sign Part 9. If you choose not to appoint an agent, you can skip part 1 and just give instructions in other Parts that you wish to fill out. However, if you fill out any Part of this document, you must also fill out Part 9, as it provides signatures and witnesses to validate the Advance Directive.
- You may use any Advance Directive form or format as long as it is properly signed and witnessed.
- You can revoke or suspend your Advance Directive at any time unless you expressly waive your right to do so.

Everyone needs an Advance Directive – not just those anticipating the end of their lives. Any of us could have an accident or suffer from an unexpected medical condition. Some of us live with a mental or physical illness that leaves us without capacity at times. Without an Advance Directive, those making decisions for you will not know what your wishes are. Worse still, your family and friends could fight over the care you should get. Help them help you – fill out and sign an Advance Directive.

This Advance Directive has 9 Parts. Fill out as few or as many Parts as you like today. If you want, you can fill out other Parts another day. This is *your* document: change it as you like so that it states your wishes in your own words. You may cross out what you don't like and add what you want.

Updating your Advance Directive

It is very important that the information in your Advance Directive is always current. Review it once a year or when events in your life change. Consider the "5 D's" as times when your Advance Directive might need to be changed or updated. The 5 D's are: Decade birthday, Diagnosis, Deterioration, Divorce or Death of somebody close to you or that affects you. All of these events may affect how you think about future health care decisions for yourself.

Whenever necessary, you should also update addresses and contact information for your agent and alternate agent and other people such as potential medical guardians whom you may have identified in your Advance Directive.

REVOKING or Suspending your Advance Directive:

You may revoke your Advance Directive by completing a new Advance Directive or completing replacement Parts of this Advance Directive. Then the old Advance Directive or Part is no longer in effect and the new one replaces it. If the new one and the old one cover different subjects, then both will be in effect.

Suspending an Advance Directive is when you want a provision to not be in effect for a period of time. For example, you may have said you wanted a DNR order and the order may have been given to you. Then you need to go in for surgery and want the understanding that you will be revived during surgery if your heart stops.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;
2. Personally informing your doctor and having him or her note that on your record;
3. Burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present; or
4. For any provision (other than designation of your agent), stating orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive.

Instructions for Part 1 - Appointment of My Health Care Agent

Appointing an agent to make decisions for you may be the single most important part of your Advance Directive. Your agent must be at least 18 years old and should be someone you know and trust. The person you choose should be someone who can make decisions for you, based upon your wishes and values. You *cannot* appoint your doctor or other health care clinician to be your agent. If you are in a nursing home or residential care facility, staff or owners cannot be your agents unless they are related to you. You can appoint an *alternate agent* to make decisions for you if your original agent is unavailable, unable, or unwilling to act for you. You can also appoint co-agents if you wish. (If you appoint co-agents, use the second page of Part 1 of this form.)

The authority of your agent to make decisions for you can begin:

- when you no longer have the ***capacity*** to make decisions for yourself, such as when you are unconscious or cannot communicate, or
- ***immediately*** upon signing the advance directive *if you so specify, or*
- when a ***condition*** you specify is met, such as a diagnosis of a debilitating disease such as Alzheimer's Disease or serious mental illness, or
- when an ***event*** occurs that you want to mark the start of your agent's authority, such as when you move to a nursing home or other institution.

The authority of your agent will *end* when you regain capacity to make your own decisions or you may specify when you want your Advance Directive to be no longer in effect.

Once your Advance Directive goes into effect, your agent will have access to all your medical records and to persons providing your care. *Unless you state otherwise* in written instructions, your agent will have the same authority to make all decisions about your health care as you have.

Your agent will be obligated to follow your instructions when making decisions on your behalf to the extent that they apply. If you choose not to leave explicit written directions in other Parts of your Advance Directive, the persons making health care decisions for you will be guided by knowledge of your values and what is in your best interest at the time treatment is needed.

ADVANCE DIRECTIVE

My Name _____ **Date of Birth** _____ **Date signed**_____

Address _____ **City**_____ **Zip**_____

Phone _____ Email: _____

Part 1 - My Health Care Agent

1. I want my agent to make decisions for me: (choose one statement below)

_____ when I am no longer able to make health care decisions for myself, or

_____ immediately, allowing my agent to make decisions for me right now, or

_____ when the following condition or event occurs (to be determined as follows):_____

---

2. I appoint _____ as my health care **Agent** to make any and all health care decisions for me, *except to the extent that I state otherwise in this Advance Directive.* (You may cross out the italicized phrase if authority is unrestricted.)

Address _____Relationship (optional)_____

_____

Tel. (daytime) _____ cellphone _____

(evening)_____ email:_____

3. If this health care agent is unavailable, unable or unwilling to do this for me, **I appoint** _____ to be my **Alternate Agent.**

Address: _____ Relationship (optional) _____

Tel. (daytime) _____ cellphone _____

(evening) _____ email: _____

And if my Alternate Agent is unavailable, unable or unwilling to do this, I ***appoint***

_____ as my **Next Alternate Agent.**

Address: _____ Relationship (optional) _____

Tel. (daytime) _____ cellphone _____

(evening) _____ email: _____

4. _____ I want to appoint two or more people to be **co-agents** and have listed them on page two of this Part.

Appointment of "co-agents"

You can appoint co-agents – people you ask to make decisions for you, acting together, based upon a discussion of your circumstance and agreement on a course of action or treatment. Sometimes co-agents have difficulty making decisions together. Before completing this part, be sure this is the best choice for you and your co-agents.

Not all of the people you ask to be co-agents may be readily available to speak for you or to make decisions that have to be made immediately, particularly in an emergency. For this reason, it is a good idea to give additional directions about how decisions can be made by your co-agents.

5. Co-agents I appoint are:

Name _____ **Relationship (optional)**_____
Address _____
Phone (specify work, home or cell)_____
_____

Name _____ **Relationship (optional** _____
Address _____
Phone (specify work, home or cell) _____
_____

Name _____ **Relationship (optional)** _____
Address _____
Phone (specify work, home or cell) _____
_____

(repeat below for additional co-agents)

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6. I prefer that decisions made by the co-agents named above be made in the following way (you may choose one or prioritize 1,2,3):
_____ by agreement of all co-agents
_____ by a majority of those present, or
_____ by the first person available, if it is an emergency.

7. Other Instructions for co-agents (optional):

Instructions for Part 2 – Others who may be involved in my care.

Part 2 is where you can list your current doctor or clinician with address and phone number. This will help by identifying someone who knows your medical history.

You can also state who else should or should NOT be consulted about your care.

You can state who is to be given information about your medical condition. This list might include your children, even if they are minors, or your close friends. Hospitals are required to withhold information about your condition from people unless you or your agent gives permission that this can be shared.

You can state who shall not be able to challenge decisions about your care in court actions. Normally any "interested individual" can bring an action in Probate Court regarding decisions made on your behalf. "Interested individuals" are your spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneficiary, clergy person or any adult who has exhibited special care and concern for you and who is personally familiar with your values. If there is someone in that list that you do *not* want to be able to bring an action to protect you, you may record the name of that person in Part 2.

Sometimes a court appoints a medical guardian for a person, and that person controls specific treatment decisions. You can state a preferred person that you would like the court to consider - if a medical guardian is being appointed. This might be the same person you chose as an agent or it might be someone else.

My Name _____ **DOB**_____ **Date** _____

Part 2 Others Who Are or May Become Involved in My Care

1. My Doctor or other Health care Clinician:

Name _____ Address _____
Phone_____

(or) Name _____ Address _____
Phone _____

2. Other people who MAY be consulted about medical decisions on my behalf:

_____

_____

Those who should NOT be consulted:

_____

3. My health care providers may give information about my condition to the following adults and minors:

_____

_____

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this Advance Directive.
Name:_____ Address_____

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5. If I need a **medical guardian** in the future, I ask the court to consider appointing the following person:

____ My health care agent

____ The following person:

Name_____ Address_____

Phone_____

Alternate potential guardians may be listed as well.

Instructions for Part 3 – Statement of Values and Goals

Part 3 allows you to state in your own words what is most important to you as you think about medical care you may receive in the future. This will guide your agent and your health care providers and will let them know why you think particular choices are important based upon your own values and beliefs.

If you choose to fill out this Part, you may wish to use the Worksheet 1 *Values Questionnaire* that is in the VT Ethics Network booklet "Taking Steps" for help in framing and sharing your response.

You may also wish to use Worksheet 2 *Medical Situations and Treatment*. The second worksheet helps you consider how you might respond to changing circumstances and the changing chances that medical treatment may be successful.

My Name_____ **DOB**_____ **Date**_____

Part 3 - Statement of Values and Goals

Use the space below to state in your own words what is most important to you.

_____
_____
_____
_____
_____
_____
_____
_____

.... And general advice about how to approach medical choices depending upon your current or future state of health or the chances of success of various treatments.

_____
_____
_____
_____
_____
_____

Instructions for Part 4 - End of Life Wishes.

Part 4 contains statements that you can use to express either a desire for continued treatment or a desire to limit treatment as death approaches or when you are unconscious and unlikely to regain consciousness.

Part 4 allows you to include other things that may be important to you, such as the type of care you would want and where you hope to receive that care if you are very ill or near the end of your life.

There may be other issues about health care when death is not expected or probable. These treatment issues and choices you can address in Parts 5 and 6 if you wish.

There may be questions about your survival that even doctors cannot predict accurately in your case. It is important to repeat that Part 4 is for those situations where you are <u>not</u> likely to survive or to continue living without life-sustaining treatment on a long-term basis.

My Name _____ DOB_____ Date _____

Part 4 End of Life - Treatment Wishes

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose all that apply):

1. _____ I **do** want all possible treatments to extend my life. **Or**

2. _____ I **do not** want my life extended by any of the following means:

    ____ breathing machines (ventilator or respirator)

    ____ tube feeding (feeding and hydration by medical means)

    ____ antibiotics

    ____ other medications whose purpose is to extend my life

    ____ any other means

    _____Other (specify) _____

3. _____ I want my **agent to decide** what treatments I receive, *including tube feeding.*

4. _____ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. _____ I want **pain medication** to be administered to me even though this may have the *unintended effect* of hastening my death.

6. _____ I want **hospice** care when it is appropriate in any setting.

7 _____ I would prefer to **die at home** if this is possible.

8. Other wishes and instructions: (state below or use additional pages):

_____
_____
_____
_____
_____
_____

Instructions for Part 5 - Other Treatment Wishes.

Part 5 addresses situations which may be temporary, long-term or which may be part of a health crisis that might become life ending for you if no treatment was given or if it was unsuccessful.

You may want to state your wishes regarding a **"Do Not Attempt Resuscitation" Order (DNR Order)** if your heart were to stop (statement #1). Such an order must be written and signed by your doctor. Either the completed written order, or a special bracelet or other identification of that order, needs to be available for any emergency first responders who are called to the scene when your heart stops. It is up to you or your agent to make sure that these additional steps are taken, including having your doctor complete and sign the order and give you either a copy of the order or some other identification.

You may be in a situation in which there is a chance for recovery but, without treatment, you might die. Statement #2 is about allowing a **"trial of treatment"** in situations like these. This means you want to start treatments that will sustain your life, such as breathing machines or tube feeding, to see if you will recover. If these life sustaining treatments are not successful after a period of time, you give your agent and other care providers permission to stop or withdraw them.

Other statements in this Part concern your wishes about hospitalization and treatment as well as participation in medical student education, or clinical or drug trials as part of your treatment.

There is also a statement about mental health treatment and your preferences concerning types of involuntary treatment.

Statement 9 of this Part concerns specific directions for prescribing and conducting electro-convulsive therapy (ECT) sometimes called "electro-shock" treatment.

If certain statements of Part 5 do not concern or apply to you, do not feel you have to address them. If you have an agent, that person will make decisions for you should the need arise.

Name _____ DOB _____ Date _____

Part 5 - Other Treatment Wishes

1. _____ **I wish to have a Do Not Resuscitate (DNR) Order** written for me.

2. _____ If I am in a critical health crisis that may not be life-ending and **more time is needed** to determine if I can get better, I want treatments started. If, after a reasonable period of time, it becomes clear that I will not get better, I want all life extending treatment stopped. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become **unable to think or act for myself** and will likely not improve, I do not want the following life-extending treatment:
   - ____ breathing machines (ventilators or respirators)
   - ____ feeding tubes (feeding and hydration by medical means)
   - ____ antibiotics
   - ____ other medications whose purpose is to extend life
   - ____ any other treatment to extend my life
   - ____ Other: _____

4. _____ If the likely **costs, risks and burdens** of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are:

   _____

5. _____ If it is determined that I am **pregnant** at the time this Advance Directive becomes effective, I want life sustaining treatment.

6. **Hospitalization - If I need care in a hospital or treatment facility, the following facilities are listed in order of preference:**
   Hospital/Facility_____Address_____Tel.#_____
   Hospital/Facilty_____Address _____ Tel. #_____
   Reason for preference _____
   I would like to ***Avoid*** being treated in **the following facilities:**
   Hospital/Facility _____ Reason _____
   Hospital/Facility _____ Reason _____

7. **I prefer the following medications or treatments:** Use more space or additional sheets for this section, if needed.

_____

Avoid **use of the following medications or treatments:**
List medications/treatments:
_____ Reason:_____
_____ Reason:_____

8. Consent for Student Education, Treatment Studies or Drug Trials

____ I **do/ do not** (circle one) wish to participate in student medical education.
_____ I **do/ do not** (circle one) wish to participate in treatment studies or drug trials.

____ I authorize **my agent to consent** to any of the above.

9. Mental Health Treatment

A. Emergency Involuntary Treatment. If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order: (List by number as many as you choose. For example, 1 = first choice; 2 = second choice, etc. You may also note the type of medication and maximum dosage.)

____ Medication in pill form
____ Liquid medication
___ Medication by injection
____ Physical restraints
___ Seclusion
___ Seclusion and physical restraints combined
___ Other: _____

Reason for preferences above (optional): _____
_____

B. Electro-convulsive Therapy (ECT) or "Electro-Shock Treatment"

If my doctor thinks that I should receive ECT and I am not legally capable of consenting to or refusing ECT, my preference is indicated below:

____ I **do NOT** consent to the administration of any form of ECT.
____ I **consent/ do not consent (circle one)** to unilateral ECT
____ I **consent/ do not consent (circle one)** to bifrontal ECT
____ I **consent/ do not consent (circle one)** to bilateral ECT

____ I **consent** (or authorize my agent to consent) to ECT as follows:
___ I agree to the number of treatments the attending Psychiatrist considers appropriate.
___ I agree to the number of treatments Dr. _____considers appropriate.
____I agree to the number of treatments my agent considers appropriate.
___ I agree to no more than the following number of treatments_____.

Other instructions regarding the administration of ECT:
_____

Instructions for Part 6 - Waiver of Right to Request or Object to Treatment

Part 6 is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored.

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded.* If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say "no" when it is offered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Part will help you let your agent, and others know what you *really* want for yourself.

You must have an agent to fill out this Part.

Because this is signing away a basic right that all patients have (to refuse or to request treatment) unless a court orders otherwise, you will need to give this much careful thought. You will also have to have additional signatures and assurances at the time you fill out this Part of your Advance Directive.

If you think this Part 6 could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramifications of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke Part 6 *only when you have capacity to make medical decisions* as determined by your doctor and another clinician.

Specific instructions for filling out Part 6 are as follows: For your agent to be able to make healthcare decisions over your objection, you must:

- **Specify what treatments you are allowing your agent to consent to or to refuse over your objection;**
- State that you either do or do not desire the specified treatment even over your objection at the time and, further, specify your wishes related to voluntary and involuntary treatment and release from that treatment or facility;

- Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive specified treatment at a time of incapacity;
- Have your agent agree in writing to accept the responsibility to act over your objection;
- Have your clinician affirm in writing that you appeared to understand the benefits, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and
- **Have an ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee affirm in writing that he or she has explained the nature and effect of this provision to you and that you appeared to understand this explanation and be free from duress or undue influence.**

My Name _____ DOB _____ Date _____

Part 6 - Waiver of Right to Request or Object to Treatment in the Future

I hereby give my agent the authority to consent to or refuse the following treatment(s) *over my objection* if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I <u>do</u> want** the following treatment to be provided, even over my objection, at the time the treatment is offered:

   _____

   _____

   I do <u>not</u> want the following treatment, even over my request for that treatment, at the time the treatment is offered:

   _____

   _____

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.
   ____Yes _____No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.
   ____Yes _____No

4. I hereby affirm that I am knowingly and voluntarily <u>waiving the right</u> to refuse or request specified treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can *revoke* this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signed _____, Principal Date _____

Acknowledgements

Acknowledgement by Agent - I hereby accept the responsibility of consenting to or refusing the treatments specified above, even if to do so would be against the principal's expressed wishes at the time treatment is considered.

Signed: _____(Agent)and_____(Alternate)
Print names:)_____ _____
Phone Numbers: Date_____

Acknowledgement of principal's clinician - I affirm that the principal appears to understand the benefits, risks, and alternatives to the health care specified above that is being consented to or refused by the principal.
Signed: _____Title____ Facility ____
Date_____Please print name: _____

Acknowledgement by persons who explain Part 6 - I, as the designated person to explain Part 6, affirm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

- Explained the nature and effect of this Waiver of the Right to Request or Object to Treatment to the principal, and
- The principal appears both to understand the nature and effect of this provision and to be free from duress or undue influence.

- If the principal is in a hospital at the time of signing, that I am not affiliated with that hospital, and
- I am not related to the principal, a reciprocal beneficiary, or the principal's clergy or a person who has exhibited special care and concern for the principal.

Signed: _____Position _____ Date _____

Instructions for Part 7 - Organ and Tissue Donation

Part 7 of your Advance Directive allows you to state your wishes about organ and tissue donation.

In some European countries organ donation is mandatory unless the patient has objected in advance. In our country permission for organ donation is not assumed and often the family or next of kin are approached for donation at the time of an accidental or unexpected death. If there are any objections from the family, those reservations and refusals are honored. Consequently, many people who may have wanted their organs and tissues to benefit others do not get to have their wishes honored. That is one reason why there is such a shortage of usable organs and tissues for transplant in our country and why many people die waiting for needed transplants.

Although you may elect to have an agent or your family decide on organ and tissue donation, your organs are more likely to be of use for others if you make the decision yourself.

You should also note your wishes on your license and attach the sticker showing that you wish to be an organ donor. You do not have to have an Advance Directive form filled out to show evidence of your wishes to be an organ donor, particularly if your license identification includes your wishes about organ donation.

If you wish to donate your body for research to a medical school you will need to contact that institution to make separate arrangements and fill out forms supplied by that institution.

My Name _____ **DOB** _____ **Date** _____

Part 7 - ORGAN and TISSUE DONATION

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

_____**I wish to donate the following organs and tissues:**

____ any needed organs or tissues

____ major organs (heart, lungs, kidneys, etc.)

____ tissues such as skin and bones

____ eye tissue such as corneas

_____ I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

_____ **I do <u>not</u> wish to be an organ donor.**

Instructions for Part 8 - Disposition of My Body after Death

Part 8 allows you to give directions about funeral arrangements or related wishes about the final disposition of your body after you die.

You can use the section to appoint an agent for making these arrangements, or you may say that family members should decide. You can give directions to whoever is in charge.

You can list important information about any pre-need arrangements you have made with a funeral home or cremation service or about the location of family burial plots.

You may indicate your permission to have an autopsy done on your body after your death. An autopsy is generally not suggested or needed when the cause of death is clear. If an autopsy is suggested, it could be helpful to your agent or family to know your wishes about having an autopsy performed. Autopsies may be *required* in cases where abuse, neglect, suicide or foul play is suspected.

My Name _____ **DOB**_____ **Date** _____

Part 8 - My Wishes for Disposition of my Body after my Death

1. My Directions for Burial or Disposition of My Remains after Death.

_____ I want a funeral followed by burial in a casket at the following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased): _____

_____I want to be cremated and want my ashes buried or distributed as follows:

_____

_____ I want to have arrangements made at the direction of my agent or family.

Other instructions:_____

(For example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)

2. Agent for disposition of my body (select one):

____ I want my **health care agent** to decide arrangements after my death; if he or she is not available, I want my alternate agent to decide.

_____I appoint the following person to decide about and arrange for the disposition of my body after my death:

Name _____ Address_____

Telephone _____ Cellphone_____ Email_____

(or)

_____ I want my family to decide.

3. If an autopsy is suggested following my death:

_____ I support having an autopsy performed.

_____ I would like my agent or family to decide whether to have it done.

4. I have already made funeral or cremation arrangements with:

Name_____Tel._____

Address_____

Instructions for Part 9 - Signature and Witnesses

Congratulations! You have done much good work in sharing your wishes through the completion of your Advance Directive.

Be sure that your wishes as stated in the Parts you have chosen to fill out make sense when read together as a whole. If there is a question of conflicting wishes, be sure that you have indicated your priorities.

When you sign your Advance Directive, you must have **two adult witnesses.** Neither witness can be your spouse, agent, brother, sister, child, grandchild or reciprocal beneficiary. A change in Vermont law has made it a little easier to have witnesses available to assist you. For example, your health care or residential care provider and their staff now *can* be witnesses of Advance Directives.

If you are in a hospital, nursing home or residential care facility when you complete your Advance Directive, you will need a third person's signature to certify that he or she has explained the Advance Directive to you and that you understand the impact and effect of what you are doing. In a health care facility, this third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson or a Probate Court designee. (Note: If you decide to include **Part 6** when you are in a health care facility, you must be sure that the third person who signs your document in that Part is not affiliated with or employed by the health care facility.)

Distribution of Copies of this Document

It is a good idea to make sure that your agent, your family, your personal physician and your nearest hospital or medical facility all have copies of this Advance Directive. List the people to whom you give copies at the end of Part 9 of the Advance Directive form. This will be make it easy for you to remember to tell all of these people if you decide to cancel, revoke or change this document in the future.

By mid - 2006 you will also have the option to have your advance directive scanned into an electronic databank called an **Advance Directive Registry** where you, your agent, your health care facility and others you designate, can get copies of your advance directive (including special personal handwritten instructions) immediately.

My Name _____ **DOB** ____ **Date**_____

Part 9 - Signed Declaration of Wishes

I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death,) and that I am signing this Advance Directive of my own free will.

Signed _____ Date_____

(Optional) I affirm that I have given or will give copies of my Advance Directive to my Agent(s) and Alternate Agent(s) and that they have agreed to serve in that role if called upon to do so.
Signed _____ Date: _____

(Optional) I affirm that I have given or will give a copy of my Advance Directive to my Doctor or Clinician.
Signed _____ Date: _____

Acknowledgement of Witnesses - I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed _____ Date _____
Print name: _____

Signed _____ Date _____
Print name:_____

Acknowledgement by the person who explained this Advance Directive if the principal is a current patient or resident in a *hospital, or other health care facility.*

I affirm that:

- the maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Name_____Address _____

Title/position_____Date _____ Tel. _____

Important!

Please list below the people and locations that will have a copy of this document:

_____**Vermont Advance Directive Registry** (anticipated available by mid- 2006)

____ **Health care agent(s)**

____ **Alternate health care agent**

_____ **Family members:** (List by name all who have copies)

Name_____ Address_____
_____
_____
_____
_____
_____

_____ **MD** (Name)_____Address_____

_____ **Hospital** (s) (Names)_____

_____ **Other individuals** or locations:

_____

_____

_____

_____

Attachment B

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Addressograph

Instructions:

- May be used for any patient, but is <u>required</u> only when a decision has been made to use less than maximal treatment
- <u>**Both sides of the form must be completed before these POLST orders can be implemented by nursing staff.**</u>
- This document is not to be given to or completed by a patient or family member.
- <u>**Each order selected must be initialed; a checkmark will not be accepted.**</u>
- Please indicate in the standard Physician Order Sheet that POLST orders have been written (e.g., "see POLST form")

1. In the event of SPONTANEOUS CARDIOPULMONARY ARREST
   (a) _____ (initial) CPR (e.g., ACLS protocol) <u>will</u> be used
   (b) _____ (initial) CPR <u>will not</u> be used
   (c) _____ (initial) modified CPR will be used as follows

   _____

   _____

2. In the event of CARDIOPULMONARY ARREST DURING A PROCEDURE
   (for example, anesthesia, surgery, dialysis, IV injection, insertion of intravascular device, etc.)
   (a) _____ (initial) CPR (e.g., ACLS protocol) <u>will</u> be used
   (b) _____ (initial) CPR <u>will not</u> be used

3. IN SITUATIONS SHORT OF FULL ARREST, other limitation of treatment decisions include:
   _____ (initial) WITHHOLD electric shock for arrhythmia
   _____ (initial) WITHHOLD IV medications for arrhythmia
   _____ (initial) WITHHOLD pressors for treatment of hypotension
   _____ (initial) WITHHOLD endotracheal intubation and assisted ventilation
   _____ (initial) WITHHOLD transfer to Intensive Care Unit
   _____ (initial) WITHHOLD transfusion of blood or blood products
   _____ (initial) WITHHOLD other therapies (specify): _____
   _____ (initial) WITHHOLD dialysis
   _____ (initial) WITHHOLD antibiotics
   _____ (initial) WITHHOLD diagnostic tests

   _____ (initial) DO NOT INCREASE current level of ventilatory support
   _____ (initial) DO NOT INCREASE current level of pressor support
   _____ (initial) DO NOT INCREASE other therapies (specify):

   Orders limiting the use of artificially administered fluids and nutrition:
   _____ (initial) NO total parenteral nutrition
   _____ (initial) NO IV fluids
   _____ (initial) NO substantial enteral nutrition
   _____ (initial) NO enteral fluids

If individual completing this form is not the attending/covering physician, the following must be initialed:

_____ (initial) discussed with the attending/covering physician _____ (Name) _____ (Date) _____ (Time)

Signed by: _____ (Signature) _____ Date _____ Time

_____ (Printed Name) _____ FAHC beeper

Temporary Suspension of POLST

After discussion with the patient or surrogate, a decision has been made to temporarily suspend these POLST orders during the following procedure: _____

Suspension begins: _____ Date _____ Time _____ Signature
POLST orders resume: _____ Date _____ Time _____ Signature
(to be signed at time orders resume)

OVER - Both sides of form must be completed

PHYSICIAN PROGRESS NOTE
DOCUMENTING DISCUSSION OF TREATMENT GOALS AND POLST

When orders are written which limit the amount or type of therapy which will be used for a specific patient (including DNR), an explanatory note must be written by the individual writing those orders. The note should include at least the following information:

(a) who participated in the discussion
(b) the goals of further therapy, for example
- life-prolongation, but without these burdensome modalities
- relief of symptoms, maintenance of comfort, hygiene and dignity
(c) the reasons for the decision, which might include
- the fully informed patient believes the expected burdens of treatment are greater than the likely benefits,
- written documentation of the patient's wishes (that is, an advance directive)
- the fully informed surrogate believes this is what the patient would choose
- the fully informed surrogate believes this is in the patient's best interests
- the attending physician believes there is no reasonable expectation that the treatments to be withheld or withdrawn would be effective.

Physician completing form:

Print _____ Signature _____

Beeper _____ Date _____ Time _____

Approval of attending/covering physician _____ Date _____ Time _____
(if completed by someone other than attending MD, must be countersigned within 36 hours to remain valid)

Attachment C

DO NOT RESUSCITATE ORDER

Patient:_____ Date of Birth:_____

I am the **clinician** for the above-named patient (**principal**), and I certify as follows:

1. I have consulted, or made an effort to consult with, this patient, and the patient's **agent** or **guardian**:

Patient's **Agent** or **Guardian**:_____

Address & Telephone:_____

2. CHECK ONE:

☐ **Informed Consent** for this **DO NOT RESUSCITATE (DNR) Order** has been obtained from:

_____ _____

Name of Person Giving **Informed Consent** Relationship to Patient

OR

_____

Signature (If Available)

☐ I have determined that **resuscitation** would not prevent the imminent death of this patient, should the patient experience cardiopulmonary arrest. Another **clinician** has also so determined:

_____

Name of Other **Clinician** Making This Determination (Please Print)

3. This patient ☐ is ☐ is not in a **health care facility** or a **residential care facility**.

Name of Facility:_____

If this patient is in a **health care facility** or a **residential care facility**, the requirements of the facility's DNR protocol required by 18 VSA § 9709 have been met.

4. I have authorized issuance of a **DNR Identification** (ID) to this patient. Form of ID:_____

5. Under Vermont law, 18 VSA § 9708(c), every **health care provider**, **health care facility**, and **residential care facility** must honor a **DNR Order** or a **DNR Identification** unless the provider or facility:

Believes in good faith, after consultation with the agent or guardian where possible and appropriate, that:

- the principal wishes to have the **DNR Order** revoked; or
- the principal with the **DNR Identification** is not the individual for whom the **DNR Order** was issued

AND

- documents the basis for that belief in the **principal's** medical record.

This **DNR Order** precludes efforts to **resuscitate** only in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient.

Dated:_____

_____ _____

Signature of **Clinician** Signature of Additional **Clinician** if No Informed Consent

_____ _____

Printed Name of **Clinician** Printed Named of Additional **Clinician**

Note: The statutory definitions of terms in bold appear on the reverse side of this Order.

§ 9701. Definitions

As used in this chapter:

(1) "Advance directive" means a written record executed pursuant to section 9703 of this title, which may include appointment of an agent, identification of a preferred primary care clinician, instructions on health care desires or treatment goals, an anatomical gift as defined in subdivision 5238(1) of this title, disposition of remains, and funeral goods and services. The term includes documents designated under prior law as a durable power of attorney for health care or a terminal care document.

(2) "Agent" means an adult with capacity to whom authority to make health care decisions is delegated under an advance directive, including an alternate agent if the agent is not reasonably available.

(3) "Capacity" means an individual's ability to make and communicate a decision regarding the issue that needs to be decided.

(A) An individual shall be deemed to have capacity to appoint an agent if the individual has a basic understanding of what it means to have another individual make health care decisions for oneself and of who would be an appropriate individual to make those decisions, and can identify whom the individual wants to make health care decisions for the individual.

(B) An individual shall be deemed to have capacity to make a health care decision if the individual has a basic understanding of the diagnosed condition and the benefits, risks, and alternatives to the proposed health care.

(4) "Clinician" means a medical doctor licensed to practice under chapter 23 of Title 26, an osteopathic physician licensed pursuant to subdivision 1750(9) of Title 26, an advance practice registered nurse licensed pursuant to subdivision 1572(4) of Title 26, and a physician's assistant certified pursuant to section 1733 of Title 26 acting within the scope of the license under which the clinician is practicing.

(5) "Commissioner" means the commissioner of the department of health.

(6) "Do-not-resuscitate order" or "DNR order" means a written order of the principal's clinician directing health care providers not to attempt resuscitation.

(7) "DNR identification" means a document, bracelet, other jewelry, wallet card, or other means of identifying the principal as an individual who has a DNR order.

(8) "Emergency medical personnel" shall have the same meaning as provided in section 2651 of Title 24.

(9) "Guardian" means a person appointed by the probate court who has the authority to make medical decisions pursuant to subdivision 3069(b)(5) of Title 14.

(10) "Health care" means any treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services provided pursuant to a clinician's order, and services to assist in activities of daily living provided by a health care provider or in a health care facility or residential care facility.

(11) "Health care decision" means consent, refusal to consent, or withdrawal of consent to any health care.

(12) "Health care facility" shall have the same meaning as provided in subdivision 9432(7) of this title.

(13) "Health care provider" shall have the same meaning as provided in subdivision 9432(8) of this title and shall include emergency medical personnel.

(14) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, codified at 42 U.S.C. § 1320d and 45 C.F.R. § § 160-164.

(15) "Informed consent" means the consent given voluntarily by an individual with capacity after being fully informed of the nature, benefits, risks, and consequences of the proposed health care, alternative health care, and no health care.

(16) "Interested individual" means:

(A) the principal's spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneficiary, or clergy person; or

(B) any adult who has exhibited special care and concern for the principal and who is personally familiar with the principal's values.

(17) "Life sustaining treatment" means any medical intervention, including nutrition and hydration administered by medical means and antibiotics, which is intended to extend life and without which the principal is likely to die.

(18) "Nutrition and hydration administered by medical means" means the provision of food and water by means other than the natural ingestion of food or fluids by eating or drinking. Natural ingestion includes spoon feeding or similar means of assistance.

(19) "Ombudsman" means an individual appointed as a long-term care ombudsman under the program contracted through the department of aging and independent living pursuant to the Older Americans Act of 1965, as amended.

(20) "Patient's clinician" means the clinician who currently has responsibility for providing health care to the patient.

(21) "Principal" means an adult who has executed an advance directive.

(22) "Principal's clinician" means a clinician who currently has responsibility for providing health care to the principal.

(23) "Probate court designee" means a responsible, knowledgeable individual independent of a health care facility designated by the probate court in the district where the principal resides or the county where the facility is located.

(24) "Reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of a principal's health care needs, and willing and able to act in a timely manner considering the urgency of the principal's health care needs.

(25) "Registry" means a secure, web-based database created by the commissioner to which individuals may submit an advance directive or information regarding the location of an advance directive that is accessible to principals and agents and, as needed, to individuals appointed to arrange for the disposition of remains, organ procurement organizations, tissue and eye banks, health care providers, health care facilities, residential care facilities, funeral directors, crematory operators, cemetery officials, and the employees thereof.

(26) "Residential care facility" means a residential care home or an assisted living residence as those terms are defined in section 7102 of Title 33.

(27) "Resuscitate" or "resuscitation" includes chest compressions and mask ventilation; intubation and ventilation; defibrillation or cardioversion; and emergency cardiac medications provided according to the guidelines of the American Heart Association's Cardiac Life Support program.

(28) "Suspend" means to terminate the applicability of all or part of an advance directive for a specific period of time or while a specific condition exists.—Added 2005, No. 55, § 1, eff. Sept. 1, 2005.

ATTACHMENT D

Do Not Resuscitate (DNR) Identification

18 VSA § 9701(7) defines "DNR identification" as "a document, bracelet, other jewelry, wallet card, or other means of identifying the principal as an individual who has a DNR order."

The Department of Health, Emergency Medical Services, supports a **bracelet system** and recommends that every person for whom a DNR order is issued have a bracelet.

Bracelets are preferred over necklaces, wallet cards, or similar alternatives as they tend to be more easily located, less likely to be transferred to another party, and do not require searching a wallet to find. Any bracelet system that is put into place should have the following attributes:

- The bracelet be of a standard design with the same information as the order form.
- The bracelet be of a color and design that is easily visible and distinctive.
- The bracelet be latex free and easily worn by persons of varying sizes and medical conditions.
- The system be inexpensive (ideally free to the patient).
- The system for requesting and receiving a bracelet should be based in the physician community (where the DNR orders are created) rather than with the Department.
- Any bracelet system should be backed up with a standardized written DNR order form. This way a patient could have an order form and no bracelet or an order form and a bracelet, but not a bracelet with no order form.

Some bracelet sources include:

- Appomattox Drug Store, PO Box 489, Appomattox, VA 24522. Telephone 1-800-330-7225 ex. 102, or order on-line at:
  http://www.diabeticdrugstore.com/dept.asp?dept_id=400

- Medic Alert Foundation International, Attn. DNR, 2323 Colorado Avenue, Turlock, CA 95382 Phone: 1-888-633-4298, 3, 1 or ask for DNR.
  http://www.medicalert.org/Main/advancedirectives.aspx

- Medical Identification Jewelry (on-line orders only) at:
  http://www.medicalidalertbracelet.com/product.asp?dept_id=401&sku=010-001&dnr=y
  http://www.medicalidalertbracelet.com/default.asp

The Department of Health does not endorse any specific vendor.

If a DNR order is withdrawn, any DNR identification should be destroyed.

Attachment E
Emergency Medical Standards

DO NOT INITIATE RESUSCITATION (DNR)- Vermont EMS Protocols 5-00

General Considerations-

A. This protocol is intended to cover patients in the health care system who have valid do-not-resuscitate (DNR) physician orders. This can include patients in health care facilities or under care in an out-of-facility setting (e.g. hospice care at home).
B. In cases where the patient is competent, EMS personnel should attempt to verify the patient's desire for no resuscitation attempts.
C. Emergency medical services must be provided to all persons regardless of resuscitation status, so that terminally ill patients have access to emergency palliative care and patients who decline CPR have access to other life-sustaining treatments.
D. DNR simply means do not initiate CPR (ventilations or compressions), defibrillation, advanced airway techniques (e.g. ET or EOA), resuscitation drugs or other resuscitation measures. It does not affect other EMS care. Comfort care measures may include positioning, temperature/environmental control, oral or nasal airways, suctioning, splinting, oxygen, IVs by on-line medical direction, assisted medications, etc.

Procedure-

A. Care other than resuscitation measures should be initiated for patients with known DNR orders.
B. EMS Personnel should verify the physician's written order. Where possible, the name of the physician and the date the order was created should be obtained and noted on the EMS run report. Hospice or the Home Health Agency involved may be able to provide assistance.
C. If possible, EMS personnel should attempt to verify with the patient, patient's legal guardian or the patient's durable medical power of attorney that the DNR order is still in effect (i.e. has not been revoked).
D. Seek on-line medical direction for circumstances not specifically covered by this protocol.

ATTACHMENT F

Experimental Treatments

The Department of Health supports a clinician's obligation to treat a seriously ill patient with all available modalities allowed by law.

All use of experimental treatments must be in compliance with 21 CFR Part 56 (Institutional Review Boards), 21 CFR Part 312 (Investigational New Drug Application), and all other applicable state and federal law.